STERILISATION

A CLOSER LOOK

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for
Initiatives: Women in Development
Western Region
Mumbai

Sterilisation - a closer look

A study of Tubectomies done in Mumbai 2002

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Preface

As members of Forum for Women's Health, population control has always been our concern especially for women who have been directly or indirectly coerced into going in for sterilisation at the cost of their health. The women's movement has constantly critiqued, confronted and struggled against hazardous contraceptives coming into the market or in the State's family planning programmes.

The thought of doing a study on sterilisation of women first came to our mind when working and staying in the tribal areas of Maharashtra. This idea got further reinforced listening to women's experiences when conducting 'Self-help trainings in Women centred health care'. We realised that more and more women preferred to have the number of children they desired and then go in for a permanent method of contraception. Whether women liked it or not they had internalised and accepted the government's small family norm policy.

The age of women going in for a tubal ligation was also decreasing rapidly. Besides there were a number of experiences that mentioned of hysterectomy following a tubectomy. This seemed really serious because healthy women submitting themselves to a surgical intervention were landing into further complications. Arising of doubts and questions and an urge to do something about this got us seriously working on this study - 'Sterilisation - a closer look'.

Initiatives: Women in Development (IWID), Western region, Mumbai, facilitated and funded this study. IWID firmly believes that population growth is not the problem or the cause of poverty and other social evils and recognises that in fact poverty is the direct consequence of increasing inequalities and dispossession. It also believes that women need safe and effective contraceptives in order to control their fertility and enjoy their sexual life without the fear of being burdened with unwanted pregnancies or harming their health.

IWID was interested in looking at the ethical issues related to sterilisation, its short and long term effects on the health of women as experienced by them and understood by the medical community. We hope that the recommendations arising out of this study will make the government realise its responsibility towards the health of women who have undergone sterilisation.

Kranti

Introduction

The government of India was one of the first in the world, to launch a national 'family planning' programme in 1951. One of its manifested intentions was provision of contraception for couples in need of them. However, the skewed nature of the official 'family planning' programme has proved that the means and methods of fertility control, have been a way of enforcing a policy of population control, rather than providing people birth control.

Female sterilisation came to be a more acceptable strategy and was given an impetus in 1977-1978, when there was a resistance to the sterilisation programme which targeted mostly men. The then ruling government gave it a new name as 'family welfare programme'.

When one looks back historically at the politics of population control both nationally and internationally, one cannot deny the eugenic intentions of those in power to wipe away the populations of those considered useless to society. They could be the poor, women, tribals, dalits, labourers, migrants or minority groups. This politics is linked to the nexus of powerful nations and elites in developing countries involved in global economics who decide on the ownership and control of resources - both material and human, control over the production processes and the market. At one level actual wars are being fought to appropriate and exploit the resources and markets of the developing nations and at another level a continuous war is being fought on the bodies of women through the population control programmes.

This becomes very obvious when we see time and again the shifts in positions and policies. In India the government at the centre projects a progressive front by bringing out a kind of positive policy. At the same time sets the states against one another to achieve the targets through incentives and disincentives. This once again affects the already deprived and marginalised populations and violates their fundamental rights. It is also a known fact that the centre has drawn up a 'Strategy Paper' the contents of which are contradictory and in opposition to that of National Population Policy 2000.

Women's need to restrict the number of children they have is an important aspect of their lives governed by unequal social conditions. This need is exploited fully by the family planning programme which has emerged to be women-focused relying on female sterilisation as a means of fertility control. Women in their desire for birth control have ended up opting for permanent methods.

In the nineties, following the mandate of the International Conference on Population and Development, the family planning programme came to be known as the reproductive and child health programme. Even with this changed terminology the targeting of women and the use of the permanent method of sterilisation for fertility control remains unaltered. In fact, the manner in which tubal ligations are performed with little concern for follow-up care and counselling, shows that sterilisation remains outside the ambit of reproductive health. This is grossly evident in the case of camps where the intention is of 'capturing' women for sterilisation. The trend of motivating them to undergo sterilisation and thereafter not paying any attention to them has been critiqued. Once they are sterilised they go out of the ambit of fertility control and do not come under the reproductive health paradigm (Qadeer:1996). Women's health needs apart from reproduction is no concern of national or international health policies.

The National Family Health Survey-II has shown that female sterilisation alone among all modern methods of contraception accounts for more than 70 percent of contraceptive use. According to NFHS-II the median age at sterilisation for women in India as a whole is 25.7 years, while for Maharashtra it is 25.0 years. Between the NFHS-I and NFHS-II, the all-India median age at sterilisation declined from 26.1 years to 25.7 years. Critiques of NFHS have time and again questioned the decline in age while totally ignoring the quality of life of women (Karkal:1998). We also felt that a point has come when scientists and scholars in the interest of ethics and advances in human reproduction should answer questions such as what could be the ideal age for tubal ligation.

Also unaddressed are the reasons and compulsions of women who form the majority seeking permanent methods. Women do not necessarily seek out sterilisation because it is the best method available. There is a need to look further and unravel the complexities of women's social and cultural lives.

The health care establishment as well as scientists researching reproductive health have never bothered to take cognition of women's problems following tubal ligation, both short term and long term. The response of dismissing women's reporting of such symptoms persist to this day and it is evident in all parts of the world (Turney: 1991).

In India where infant mortality rate is alarmingly high encouraging permanent methods is unrealistic. There is also much criticism from scholars and from

the women's movement that a permanent method is not the most efficient when child survival rate is still low (Desai and Krishnaraj: 1987; Chayanika et al:1999).

Nevertheless, given women's overwhelming choice for tubectomy and the insufficient awareness of its implications for women's health, our intention was to understand women's rationale for choice of tubectomy. We wanted to trace the process and the experiences of the morbidities through a small exploratory study in selected areas of the city of Mumbai.

Rationale and Methodology

The success of the target approach of the Family Planning programme has been questioned and criticised by many. The targeting of dalits, tribals and the urban poor is the outcome of an approach to control the fertility of the poor. This is a reflection of the eugenic aspects of population control politics. One of our prime concerns has been that the age of female sterilisation has come down rapidly.

The other important concern has been voiced by the women's movement. It has highlighted the exploitation of women's vulnerable status in society by the health establishment, targeting women for fertility control without addressing their health care needs. Men's lack of responsibility is not addressed in the family planning programmes. After the political backlash experienced in the 70s, male vasectomy has hardly a role in the family planning programme. There is a reduction in vasectomies performed and it is hardly promoted as a safe alternative and as a terminal method. Technological innovation in surgical intervention is also responsible for the drastic reduction in vasectomies.

The other danger is the resurgence in the medical and scientific lobbies' promotion of other hazardous hormonal contraceptives with little concern for its effects. Methods such as quinicrine sterilisation, stands to gain importance in the liberalised market economy.

The use of technology for assisting reproduction as well as controlling it has expanded emphasising invasive techniques to be used on women's bodies. In terms of budgetary allocations family welfare gets a major proportion compared to health outlays. Post-tubectomy health care is beyond the purview of present understanding of family welfare.

An exhaustive review by Lyn Turney has shown that there is much evidence in medical literature that irreversible damage is caused due to tubal ligation. There are reports of the problems that women suffer but women's own perceptions of these very problems are trivialised. Women are not informed of the likelihood of these problems occurring following tubal ligation. Further, their perceptions are ignored and the myth of the 'safety' of ligation is perpetrated (Turney:1991).

In the late 80's Sabla Sangh, Delhi, conducted a study on the socio-medical impact of sterilisation on the lives of women in four resettlement colonies of Delhi (Sabla Sangh 1989). We share the concerns and wish to review the

situation after a decade following structural adjustment programmes in a different context in Mumbai.

One of the important objectives of this study was to associate the morbidities that women report with the tubectomy process and outcome, and advocate for safeguards in existing procedures, sufficient care and follow up. In this context it becomes imperative that women are informed of the process of medical intervention and its risks. We feel the need to advocate for special primary health care to address the needs of tubectomised women.

We are unable to comprehend the pressures of women opting for sterilisation in such large numbers and at a very young age. They are not aware of its effects in the long run. This area of early tubal ligation, its consequences and the kind of intervention needed is not explored.

The objectives of the study are:

- To document women's perceptions and experiences of sterilisation.
- To understand why and how tubectomy becomes a choice within the family.
- To document the immediate and long term complications linked to tubectomy.
- To record the sequel of surgery and its co-relation with hysterectomy.
- To make note of the possible social problems – failure of the operation, changes in relations, feeling of desertion, protection against STIs etc.
- As long as women prefer this method advocate for a milieu where it can be done in safe and humane conditions.

Methodology of the study

The study was undertaken in select lower socio-economic (slum) settlements in the Central and Western suburbs of the city of Mumbai. In the western suburbs, ward M east, Malwani and ward H east, Bandra/ Santa Cruz were visited, while in the central suburbs, ward G North, Dharavi was visited. A total of 244 women were requested to respond to semi-structured interview schedules. They were approached between the months of October 2001 and January 2002, through the community health volunteers (CHV) attached to

the Brihanmumbai Municipal Corporation health posts, as well as volunteers of some local non-governmental organisations working in the areas.

The sampling of the women respondents was through a snow-balling approach, where one woman led us to another, who then related to us her experiences of sterilisation. As far as possible we approached women who had a longer period of time following their sterilisation, but it ranged between 2 years to even 20 years. We know the number of women interviewed is small, but at the same time it gives us an idea of the magnitude of the problem.

The semi-structured interview schedule focused on the following issues: women's relationship to contraception, the rationale for sterilisation, the context for sterilisation, operative and post-operative condition, problems following sterilisation. We also looked into the possible association of tubectomy with hysterectomy and women's knowledge/ experience of STIs and HIV-AIDS.

Using a semi-structured interview schedule allowed us to elicit from women significant qualitative data in the form of extended discussions on diverse aspects of their lives. This information also supported the quantitative data. We also interviewed a few private practitioners and doctors from the municipal corporation's maternity homes to obtain the picture from the other side. In the course of the administration of the questionnaire we did come across a lot of limitations and shortcomings which we could have corrected. When asking for the socio-economic details we missed out on the literacy levels of women and in our list of effects of tubectomy, we also lost out on some aspects of morbidity such as acidity and flatulence.

It was our intention to entirely rely on women's perception of sterilisation, contraception and the rest of the changes in their bodies and posit it vis-à-vis doctors' perception. It is important to rely on women's perception, because despite the fact that it is they who experience sterilisation and its implications, it is the medical science and its practitioners who claim to represent the nature of experience and its validity.

Due to the nature and design of our study we have not attempted to derive a cause-effect relationship vis-à-vis tubectomy and morbidities. We have tried to establish the magnitude and strength of association of the morbidity pattern among tubectomised women. We need to state at the outset therefore that we did not rely on any clinical examination of the morbidities reported by women.

The context of women's lives

The city of Mumbai occupies a special position attracting a lot of migratory population in search of livelihood and better options in life. People not only from the villages in Maharashtra but from many other places such as Tamil Nadu, Karnataka, Uttar Pradesh have migrated and settled in Mumbai to make a living.

Mumbai occupies a unique position vis-à-vis the health services system. The establishment of the India Population Projects has put in place health posts and the scheme of community health volunteers, to provide people with better health and family planning services. Women who were part of our study belonged to Dharavi, Thane, Chembur, Malwani (Malad), Behrampada (Bandra), and Golibar (Santa Cruz-East).

The slum in Dharavi is the largest in Asia. All the houses are situated close to one another. There is a lack of fresh air, the presence of overflowing open gutters and an overall lack of cleanliness. Women live and work in this situation. Here all the women do home-based work. Most of them are involved in making products out of leather and work from a fixed place. Some women work as domestic helpers. These women do not earn very much. Many of their husbands are addicted to alcohol and drugs.

Most of the women who live in the *bastis* in Thane have come here only after their marriage. Some of these women are engaged in home-based garment making, while others work as domestic helpers. Some women do only household work. The houses of this *basti* are situated at the bottom of a hillock. They are small in structure as *chawls* and are very close to one other. Most of the houses are owned by the inhabitants.

The *basti* at Malwani, Malad, has a large population of Muslims and Hindus of different castes. The Muslim community is predominant. The families living here are basically low-income groups and daily wage earners. Most of the men do not have jobs, are under the influence of alcohol and some are also drug addicts. The women have to earn and run the household by working as domestic helpers or they bring work home and do it as piece work. Large families have to accommodate themselves in small single rooms. Water and toilet facilities are common for many houses. This *basti* is one of the largest slums, highly populated with meagre amenities and poor living conditions. The first impression on entering a home in this basti is that of a woman trying to balance her housework, children, in-laws and the work that is brought from outside

which the woman tries to complete in between all her responsibilities. If she has daughters they are also involved in this work.

Most of the women who were interviewed from Golibar in Santa Cruz, do home-based work, such as garment making. They work on machines the entire day and then attend to their housework. Availability of amenities such as water supply is slightly better than in other areas.

In Behrampada in Bandra, the part where women were interviewed was destroyed completely in the 1991-92 communal riots. All the people living here are Muslims. This slum is quite dirty and there is inadequate water supply. The houses are so crowded that there seems no space for air to enter. Due to the crowding of the houses, there is hardly any sunlight streaming into the houses. There is also considerable pollution in this area. Most of the women here are domestic workers.

Socio-demographic profile

Given our snowballing sampling of locating the women respondents who had done sterilisation, our study showed that, of all the women interviewed, Hindus were the predominant group (72.9 per cent) followed by Muslims (23.8 per cent) (Table 1).

Table 1 - Religious groups to which women belonged

Religion	No. of Women
Hindu	178 (72.9%)
Muslim	58 (23.8%)
Christian	3 (1.2%)
Buddhist/Neo-Buddhist	5 (2.1%)
Total	244 (100)

Source: Survey data, 2002

Table 2 shows that among the women we approached, about 20.5 per cent were from the Dalit (SC) community, while nearly 22.5 per cent were from the other backward castes. Even the Muslim women distinguished themselves in terms of different groups and gave themselves a caste identity. About 32 per cent were from the forward community. The groups among each of these categories is given in the note below Table 2.

Table 2 - Castes/ social groups to which women belonged

Caste/ Social group	No. of women
SC	50 (20.5%)
OBC	55 (22.5%)
FC	78 (32.0%)
Muslim	58 (23.7%)
Christian	3 (1.3%)

Source: Survey data, 2002

Note: OBCs (other backward castes) include, Naik, Navhi, Sonar, Bhandari, Yadav, Gurav, Koli, Khanderi, Malwani, Mayavanshi, Panchal
FCs (forward castes) include Baniya, Brahmin, Patel, Kunbi, Maratha
Muslims also had the following groups: Sheikh, Khan, Pathan, Ansari, Qureshi, Shamsi, Sayyed, Kermani

Occupation

157 (64.3%) out of 244 were doing work within the household, while 82 (33.6%) women did both paid work outside as well as work within the household. A majority of the women did stitching 'taka' (35), domestic workers (17), workers in the hospital (3), community health volunteers/balwadi workers (5), and vegetable sellers (4).

Pregnancies and abortion

200 women had between 2 to 5 pregnancies (Table 3). There was 1 woman who had only one pregnancy, and one woman each who underwent 9, 10, and 11 pregnancies. Age at tubectomy of those having maximum pregnancies (9,10,11) were between 30 and 33 years of age. Among those women who had more than 5 pregnancies, the reason given was son-preference. Some women had also gone for sex-determination tests.

Table 3 - Number of pregnancies women had

No. of pregnancies	2	3	4	5	6	7	8	Total
No. of women	32	68	61	39	20	15	5	240

Source: Survey data, 2002

Those who had 3 pregnancies and more, the child mortality is quite significant (Table 4). Of the 68 women who had 3 pregnancies, only 41 had all three children living, while 26 had only two live children. Similarly, of those who had 4 and 5 pregnancies, half of them had lost one or more children.

Thus there is a disjunction when reproductive and child health or family welfare is addressed. Government policies do not offer health care services to people nor assure them of the survival of their children. The commonsensical linkage that people have of their lives, women's decision to accept sterilisation and child survival is absent when government frames policies and offers health care services to people.

Table 4 - Child mortality in terms of pregnancies of women

Pregnancies	Live Children								
	1	2	3	4	5	6	7	10	Total
1	1								1
2		32							32
3	1	26	41						68
4		9	28	24					61
5		1	9	16	13				39
6		2	8	2	7	1			20
7		1	2	6	3	2	1		15
8					1	4			5
9							1		1
10								1	1
11							1		1
Total	2	71	88	48	24	7	3	1	244

Source: Survey data, 2002

26 (10.6%) women underwent a spontaneous abortion in the course of their pregnancies. Those who had 6 to 9 pregnancies underwent two or more miscarriages (Table 5).

Table 5 - Spontaneous abortions women had

Pregnancies	Spontaneous Abortions			
	0	1	2	Total
1	1			1
2	32			32
3	65	3		68
4	55	6		61
5	31	8		39
6	12	6	2	20
7	11	2	2	15
8	4		1	5
9			1	1
10	1			1
11		1		1
Total	212	26	6	244

Source: Survey data, 2002

About 23 per cent women had at least one MTP. Another 6 per cent had 2 to 4 MTPs done (Table 6). Women have come to adopt MTP as a contraceptive method quite routinely, speaking volumes of their lack of negotiation with partners and the willingness of the health services system to provide women with abortion rather than speak to the men on their reproductive responsibilities.

Table 6 - Medical Termination of Pregnancy women underwent

Pregnancies	Medical Termination of Pregnancy					
	0	1	2	3	4	Total
1	1					1
2	32					32
3	49	18	1			68
4	39	19	3			61
5	29	8	1	1		39
6	10	6	2	1	1	20
7	9	4		2		15
8	1	1	3			5
9	1					1
10	1					1
11	1					1
Total	173 (70.9%)	56 (22.9%)	10 (4.1%)	4 (1.6%)	1 (0.4%)	244 (100)

Source: Survey data, 2002

Age profile of the women

Out of the 244 women who were interviewed, 80 per cent were in the age group 25-45 years (195/244) (Table 7). 213 (87.3%) of the 244 women were married by 20 years of age, of whom 78 (32%) were married at 15 years of age or less. The average age of the women in this study was 36.8 years while their average age at tubal ligation was 26.2 years.

Table 7 - Present age of the women who underwent tubectomy

Present Age of Woman	No. of Women
< 25	16 (6.5%)
26-30	58 (23.7%)
31-35	53 (21.7%)
36-40	54 (22.1%)
41-45	31 (12.7%)
45-50	18 (7.4%)
>50	14 (5.7%)
Total	244 (100)

Source: Survey data, 2002

Women's experience of the processes and conditions of sterilisation

Sterilisation

Of the 244 women, 201 (82.4 per cent) were sterilised when they were below 30 years of age. 122 (50 per cent) women were sterilised when they were less than 25 years (Table 8). Of course, this has been happening over many years and does not speak for women sterilised in the recent past alone. Thus the health services have consistently been conducting sterilisations on younger women. As the doctors we interviewed had to say, '*is it not good that women complete their families and be relieved of further pregnancies?*'

It was also interesting to note that the doctors' approach to a successful sterilisation was not in terms of lack of morbidities that the women may present with but the women not getting pregnant again. From this it becomes very clear that post-sterilisation morbidities that women suffer are not a concern of the health and medical care system.

Table 8 - Present age of woman and her age at sterilisation

Present age of Woman (years)	Age at Tubectomy (years)							
	<20	21-25	26-30	31-35	36-40	>40	Don't know	TOTAL
< 25	4	12						16
26-30	5	37	16					58
31-35	4	24	19	6				53
36-40	4	19	21	8	2			54
41-45	0	7	15	8	1			31
45-50	1	4	5	6	1		1	18
>50	0	1	3	7	2	1		14
TOTAL	18	104	79	35	6	1	1	244

Source: Survey data, 2002

We categorised the women into two groups - those who had been operated within a period of 10 years and those who had done it more than 10 years ago. One reason was to look at the persistence and chronicity of the post tubectomy morbidities. Another reason was to see the implications of the changing methods and procedures of sterilisation on the health of women. In this 139 (56.9%) women had done their sterilisation within a period of 10

years, while the remaining 104 (42.6%) women did it more than 10 years ago (Table 9).

Table 9 - When Women did the Sterilisation Operation

Sterilisation done*	Within 10 years	More than 10 years ago
No. of Women	139 (56.9%)	104 (42.6%)

Source: Survey data, 2002

*One woman could not recall the date of sterilisation

Experience with other contraception

As far as knowledge of contraception goes, 100 (41%) women knew of the condom, but only 11 women (4.5%) had used it. While 114 (46.7%) women knew of the pill, only 31 (12.7%) women had used it. While 101 (41.3%) women knew of the IUD, 26 (10.6%) alone had used it. These knowledge and perceptions are of course only of those who have done their sterilisation operation.

In general women were not at all enthusiastic about contraceptives such as the IUD or oral pills. They expressed that these were for women of higher classes and for women whom they considered sexually active or even promiscuous. Some who did use them, did so because it was not painful, no one need know about it and they could have sex in peace. On the whole their experiences were not very good and they had to discontinue them for various reasons. The women who used oral pills said they discontinued because of giddiness and black out spells and felt weak. One did not receive proper explanation and as a result got pregnant while four of them said that they forgot to take the pills hence became pregnant. Those who fitted IUD - one was forcefully fitted, the other three suffered from severe pricking lower abdominal pain, irregular bleeding and infected white discharge. Two of the women whose partners used condoms got pregnant.

Choice of tubectomy

A maximum number of women (218) chose to get tubal ligation done because they did not wish to have any more children (Table 10). 44 women, among other reasons, chose tubal ligation because of ill health. Six women were tired of other contraceptive methods, while thirty-eight women wanted to have sexual relations without any worry. 92 women feared pregnancy. 26 women did not

want more abortions. 28 women had other reasons such as pressure from husband and mother to get operated. While it seemed that there was a unanimous choice of tubectomy as a birth control method, it was a revelation that fear of unwanted pregnancies was a dominant feeling among women in terms of their approach to sexual relations and its outcome. This indicates that support and co-operation from husbands and household members is much wanting. Ill health was another major factor for women opting to do sterilisation.

In terms of numbers, sterilisation is a big success since for many women it represents a choice to be free of biological reproduction. But closer examination of conditions under which most women have consented to be sterilised shows that sterilisation abuse is a pervasive problem for poor women. While outright force has been used on some occasions, in most cases the abuses involved are more subtle. They stem from poverty and adverse social conditions, including lack of information and access to other methods of birth control, threats of discontinued social benefits and economic constraints (Bandarage: 1997).

A large number of women mentioned that it was their desperation of poverty and lack of economic support where they could just not afford another child that drove them to accept sterilisation. In such situations choice simply does not exist when reproductive decisions are tied to survival and subordination.

Table 10 - Reasons for choosing to do tubal ligation

Ill health	44
Did not want more children	218
Tired of other contraceptives	6
Wanted sexual relations without worry	38
Fear of pregnancy	92
Did not want more abortions	26
Fear of stigma	1
Other reasons	28

Source: Survey data, 2002

Inspite of their experiences of poverty it was evident that incentives hardly played a role in motivating women for tubectomy. This myth needs to be dispelled that women go for sterilisation because of payments in cash or kind. Publicity of the family planning programme was an influence though there was

apparently no pressure or coercion from the health personnel (Table 11). Our experience also shows that women were also fined Rs. 500 when they approached the public health services after they had a third child.

Table 11 - Reasons that pressurised women to choose tubal ligation

Hope of incentive	2
Poverty	152
Pressure from health workers	4
Influence of publicity	38
Others	12
No pressure	65

Source: Survey data, 2002

In terms of the outcome of sterilisation, women also perceived the success of the operation largely in terms of not conceiving and not in terms of accompanying health and well being. However there were four women who experienced failure of tubal ligation by laproscopy and who had to undergo the operation again.

Caesarean/tubal ligation failure

Shanti aged 35 years has had a bad obstetric history. She has three children all of whom were delivered through caesarean operations. Because of this she was not able to breast feed her babies as there was no milk, and long stays in the hospital caused inconvenience to the family members.

Since the first child was born through caesarean section she decided to do a tubectomy when she conceived the second child. She was only 16 years old then. The sterilisation was done in a general hospital during the second caesarean. She was hospitalised for one month and spent Rs.15,000/-. But after six years Shanti conceived again. This was a real shock to her. How could she conceive again after undergoing sterilisation during caesarean. But what could she do? She had to undergo a third caesarean operation to deliver her third child and then once again her tubes were ligated. This time Shanti had other problems. Her wound would not heal. There was pus formation at the site of the sutures. She had to stay in hospital for 3 months and again had to spend Rs.15,000/-. This time too she had to bear much pain and discomfort. She could not move for a long time. This experience has made her very frightened and also suspicious of doctors whom she feels are very careless especially when it comes to deal with the poor.

Dilemmas of an unwanted pregnancy on failure of tubal ligation

Smita at the age of 23 went in for laproscopic tubal ligation because she had three children which she thought was enough. But by the time she made up her mind she conceived again. She was convinced that with her poor economic status she would not be able to afford another child. So she went to the general hospital for an MTP and also asked them to operate on her. The doctors did a D&C and also operated on her. But after 5 years Smita conceived again. Why was her operation a failure? Did the doctors not do a proper job? Was it some fault on her side? Did she not take enough care?

Once again the dilemmas of an unwanted pregnancy was before her, due to no fault of hers. Again going to the doctors and drugging herself with pills and injections to abort... And then you don't abort but by the time you have tried all this it is too late to do an MTP... Smita was willing to undergo an MTP for two reasons: she was afraid that the foetus would have been affected with all the things she had taken to abort and secondly she really could not afford a fourth child. But doctors did not want to take a risk and so Smita delivered the fourth baby and then one more operation was performed.

Whom can we hold responsible for this kind of negligence and carelessness.....?

Use of health services

81.2 per cent of the women (198) did their tubectomy in the public hospitals, health posts, or maternity homes (Table 12). Only 13.5 per cent (33) used private sector facilities. 13 women got their tubectomy done in the camp. Thus there is clear evidence that it is the public services that the people approach for a sterilisation because of economic reasons. Most people who approach are from the lower socio-economic background. When viewed over a period of time, what is interesting is that while the public health services still command a major share of sterilisations, there is also a shift observed to the private sector (Table 13). Camps also continue to prevail.

Table 12 - Place where tubectomy was done

Place of Sterilisation	No. of Women
Camp	13 (5.3%)
Public services	198 (81.2%)
Private sector	33 (13.5%)
Total	244 (100)

Source: Survey data, 2002

Table 13 - Place of sterilisation over the period of time

Place of Sterilisation	No. of Women who did it within 10 years	No. of Women who did it more than 10 years ago
Camp	11 (7.9%)	2 (1.9%)
Public hospital	104 (74.8%)	93 (89.4%)
Private hospital	24 (17.3%)	9 (8.7%)
Total*	139 (100%)	104 (100%)

*one woman did not know how many years ago the surgery was done.

Source: Survey data, 2002

The situation in camps.

I am Sunanda and 36 years old now. When I was 25 and pregnant with my third child, I decided not to have any more children after this. I had heard about laproscopy from other women. Soon after my delivery when the school authorities arranged to take the village women to the camp for laproscopy, I also registered my name for it. A jeep was arranged to take us and bring us back from the camp.

On arriving at the camp I saw there were 25 other women besides me for the operation and also there were plenty of doctors present. I really don't know what was going on inside but the women taken inside for the operation were screaming and shouting and this frightened us all. One woman just got up and ran away and another woman was so frightened that she died of shock on the spot. This event frightened us all the more, but since we had come here we decided to go ahead with the operation.

After the operation the women were all made to lie down on the floor in the veranda since there were no beds available. When some women were screaming with pain the ayahs beat them with a ruler. We were treated like animals.

After all this the jeep that was supposed to reach us back home, left us at the foot of the hill saying the jeep cannot climb up. So holding on to our stomachs we had to climb up to our homes in the village which was on top of the hill. After such a bad experience, I always make it a point to tell other women not to go for TL operations conducted at the camps. I would not want any woman to go through these inhuman conditions at the camp.

In terms of follow-up care while 201 women were asked to come back to the hospital, women only went for removal of stitches and even this was not proportionate. Women said that the doctors called them for removal of sutures but most of the time they are not there. 141 women did not receive any follow-up care by visits from the health worker (Table 14). Only 14 women were followed up by the nurse, while 89 women were seeking care from the sources other than the public sector. Women also say that even going to

government hospitals they have to spend and wait for long hours. Hence it is better to go to private doctors.

Table 14 - Follow-up by the public health system

ANM visited	14 (5.7%)
ANM not visited	141 (57.8%)
Seeking care elsewhere	89 (36.5%)
Total	244 (100)

Source: Survey data, 2002

Motivation for tubectomy

146 (59.8%) women said that nobody registered them for the tubectomy, but they knew they had to get it done. Thus what is evident is that women are already motivated and know this to be an inevitable fact. This is an issue that needs to be seriously taken note of, as this amounts to the family planning programme having succeeded in creating a need in women to have sterilisations done. Women's preparedness, willingness, unwillingness to let men do it, acknowledgement of it as a 'custom', as their biological duty similar to childbirth were all the indications.

Linked to this is also a low sense of self-worth and a low sense of personhood that was seen as in the instance of a woman who said, *'I decided to get operated because if I die, he is likely to get remarried. Then why should the second wife not have children by him'.* Some women also shared that the failure rate in vasectomy is high and if they conceive then there is a lot of misunderstanding and suspicion. Women commonly feel that it is the men who do hard work and are the breadwinners, while they do only house work hence the men cannot get operated. It was also mentioned that men refuse to do vasectomy as they are afraid of losing their masculinity.

The fact that this choice happens with the exclusion of other contraceptive methods playing any role in spacing, is indicative of the other social and cultural factors in women's lives which the health services system refuses to acknowledge. The others who motivated women were mother, husband or neighbour.

Manner of operation

Laprotomy tubal ligation is sterilisation performed by an incision in the lower abdomen; women commonly refer to this as *takyacha operation.* Laproscopic sterilisation is performed by a small incision and the ligation of tubes by viewing through a laproscope inserted into the gas filled abdomen; women commonly call this as *currentcha operation.* 57 per cent women underwent laprotomy tubal ligation and another 3.3 per cent had the same done during caesarean section, while nearly 39.3 per cent underwent laproscopic sterilisation (Table 15).

Within the last 10 years the proportion of laproscopic sterilisations have increased tremendously (Table 16). This procedure can be done at a faster pace hence more women can be operated within a short time. Women said that they did not prefer laproscopic sterilisation even though the doctors recommended it, and would not themselves recommend it to other women.

They prefer the traditional type of tubal ligation to laproscopic sterilisation as they are aware that the possibility of failure is high. They are also scared of electric shock during the laproscopy, have fearful recollections of camp situations, trainee doctors performing on them, operations conducted at night and fear of spinal anaesthesia used during earlier times. The women's perceptions brought to our memory the violent visuals from Deepa Dhanraj's film 'Something Like a War' which depicts the sterilisations done in camp situations within a highly patriarchal medical institution.

Table 15 - The manner in which the sterilisation was done

Manner of operation	No. of Women
Laprotomy tubal ligation	139 (57.0%)
Following caesarean section	8 (3.3%)
Laproscopic tubal ligation	96 (39.3%)
Quinicrine sterilisation	1 (0.4%)

Source: Survey data, 2002

Revathy's horrendous experience when doing a Laproscopic tubal ligation

Revathy is 29 years old. A year ago her husband and she decided that they did not want any more children. They had a son and a daughter and now they should put a stop. In the meantime Revathy conceived again but since she did not want to carry on with her pregnancy she decided to do an MTP and get sterilised along with it.

Revathy got admitted in a public hospital close to where she stayed. Before they gave her the general anaesthesia and knocked her off she says that there were two doctors and three nurses who attended on her. The sterilisation was done by Laproscopic tubal ligation method.

Today when Revathy narrates her experience she is still choked with emotions of anger and fear. She almost died!

"During the operation I started bleeding and the doctors were unable to control it. I was given 15 bottles of blood. The hospital authorities immediately shifted me to Cooper hospital. There the doctors were not able to deal with the seriousness and immediately shifted me to KEM hospital. I was in the ICU for 4 days and in the ward for 12 days. On enquiry I was told that when doing the laproscopic tubal ligation a major blood vessel was cut causing excessive bleeding. The scar on my abdomen extends from 1inch above the umbilicus to the pubic region and I have 24 sutures in all. The hospital did not charge me for the shifting etc. But I spent Rs.40,000/- for medicines alone, besides another Rs.10,000 for other expenses. But the pain, anxiety and inconvenience caused to the entire family cannot be priced."

Who is to be blamed... lack of experience of the doctors, inherent risks of the procedure of laproscopic tubal ligation or just Revathy's fate?

Revathy strongly expresses that since this method is being widely used the medical community/government needs to study the procedure carefully so that women do not land up with more complications and even the risk of losing their lives.

Table 16 - The manner of sterilisation over the period of time

Manner of operation	No. of Women who did it within 10 years	No. of Women who did it more than 10 years ago
Laprotomy tubal ligation	65 (46.8%)	73(70.2%)
Following caesarean section	5(3.6%)	3(2.9%)
Laproscopic tubal ligation	69(49.6%)	27(26.0%)
Quinicrine sterilisation	-	1 (0.9%)
Total*	139 (100%)	104 (100%)

*one woman did not know how many years ago the surgery was done.

Source: Survey data, 2002

Type of Anaesthesia

132 women (54%) had spinal anaesthesia during their tubectomy (Table 17). Nowadays anaesthesia used for laproscopy is local or general anaesthesia. One of the long-term problems that women have which they related to their spinal anaesthesia was backache and headache.

Table 17 - Type of anaesthesia used during tubectomy

Type of anaesthesia	No. of Women
Local	13 (5.3%)
Spinal	132 (54.0%)
General	93 (38.1%)
Total	238*

*5 women were not sure of the anaesthesia used.
Source: Survey data, 2002

Table 18 - Type of anaesthesia used during tubal ligation over time

Type of anaesthesia	No. of Women who did it within 10 years	No. of Women who did it more than 10 years ago
Local	12 (8.7%)	1 (1%)
Spinal	64 (46%)	68 (69.3%)
General	63 (45.3%)	30 (30.6%)
Total	139	99*

*5 women who did more than ten years ago were not sure of the anaesthesia used.
Source: Survey data, 2002

Conditions of operative and post-operative care

During tubectomy women noticed that though the atmosphere was somewhat tense and crowded the place of operation was clean. 91.4 per cent of the women said that all the tests for haemoglobin, sugar in blood and urine as well as blood pressure check-up was done (Table 19). Thus as far as the operative procedures were concerned the doctors gave advice and care (Table 20). There was however some dissatisfaction when about 70 women said that they were not given medicines and that sufficient hygiene and cleanliness was not there at the time of surgery (Table 21).

22 women complained of wound infection which took almost 1 to 3 months to heal. Out of the 7 tubal ligations done during caesarean operation, 6 women had prolonged hospital stay because of wound infection and sutures not healing. All of them first went to the public health services for treatment. For 9 of these women the wound did not heal hence they switched over to private doctors and spent from Rs.1000/- to Rs.3,000/-. The others got treated in the public hospitals but it took them almost three months to get healed and return to their hard physical labour.

Table 19 - Tests for Hb, Sugar in blood and urine, and BP

All 3 tests done	223 (91.4%)
No tests done	21 (8.6%)

Source: Survey data, 2002

Table 20 - Advice and care at the time of operation

Medicines given	203
Advice on rest, refraining from sex	196
Immediate post-operative problems mentioned	58

Source: Survey data, 2002

Table 21 - Preparations done before tubectomy

Medicines given	69
Hygiene taken care	123
Nothing was done	70

Source: Survey data, 2002

What is significant of course is that while the surgical and technical aspects were kept in order by the doctors, they did not bother much to inform the women about the procedure nor what it could do to their bodies. As seen below (Table 22), 95.5 per cent women were not told anything about the surgery or its impact.

Table 22 - Information given about tubectomy at the time of surgery

Information given	11 (0.5%)
No information given	233 (95.5%)

Source: Survey data, 2002

What is worse is that one of the woman shared with us that she was operated without her knowledge. To get even one person in a group of 244 saying that operation was done without her consent is a serious offence by the medical system.

What if Heena slips from her path?

What I am going to relate now happened to me some years back. Today I can talk of it. But at that moment I was wreathing with anger. How dare they do this to me. You must be wondering what they did to me—

"I was a young widow with two small children. I used to bring work home and earn a small amount. One day I got severe abdomen pain. I went to my neighbour who is a community health worker in the near by health post. She took me to the doctor. The doctor asked me to go inside the examination room for a check up and gave me an injection which made me unconscious. When I gained consciousness and felt my abdomen, on the left side I felt wetness and some gauze stuck there". I asked my neighbour "what was all this?" She said that when treating me for my abdominal pain they also did my sterilisation. " In my drowsy state I was unable to think.. All I could say was I did not need this operation as I am a widow". But the CHV promptly said " Even if your husband is dead this is safe in case you slip from your path"- "Paay Gasarla thar?".

When I was in my full senses I realised what they had done to me. "How dare they do this without my consent, how could they operate on me? Would they have done this if my husband was alive? Would they have done it to any man who had lost his wife?

Another situation of vulnerability that women face vis-à-vis the health services system is the point at which tubectomy is done. 52.5 per cent of the women (128) had the tubectomy done immediately after delivery (Table 23), while 18.4 per cent women did it immediately following an MTP. More than half the women getting sterilised after delivery indicates the coercion prevailing in providing services. Deliveries are conducted only if they are willing to undergo the operation. In fact, after delivery complications like bleeding is possible so it is not advisable. The coercion and incentives in case of fertility control are of different kinds and these have been able to entrench the ideology so strongly that very few women reported that they were forced to undergo sterilisation.

Table 23 - The point at which tubectomy was done

Point at which tubectomy was done	No. of Women
Immediately after delivery	128 (52.5%)
Immediately after MTP	45 (18.4%)
From 2 months to years after delivery	71 (29.1%)

Source: Survey data, 2002

This also means that MTP is used by women as a contraception. The health professionals are complicit in exploiting the vulnerability that women suffer at the hands of their husbands who refuse to co-operate with them in sexual relations. In fact, within the last 10 years (Table 24) this trend of using MTP as a contraceptive method has shockingly increased and speaks of the continued vulnerability of women's gender subordination and the influence of patriarchal domination in their lives.

Table 24 - The point at which tubal ligation was done over a period of time

Point at which tubectomy was done	No. of Women who did it within 10 years	No. of Women who did it more than 10 years ago
Immediately after delivery	52 (37.4%)	75 (72.1%)
Immediately after MTP	39 (28.1%)	7 (6.7%)
From 2 months to years after delivery	48 (34.5%)	22 (21.2%)
Total*	139 (100%)	104 (100%)

*one woman did not know how many years ago the surgery was done.
Source: Survey data, 2002

Association of Sterilisation and morbidities

The fact that women do not approach the public health system for post-operative care does not mean that women do not experience various types of immediate problems (Table 25) and long term morbidities (Table 27). Women are very clear and sure of their articulation of morbidities and its association with tubal ligation. There have been studies which have found at least higher gynecological morbidities among those who did tubal ligation than other women.

43.8 per cent (107) women said they did not experience any immediate post-operative problems while rest of the women had a combination of problems (Table 25) ranging from general weakness to menstrual disorders and aches and pains. Among those, 86 women who had tubectomy immediately following delivery, 74 of them could attend to the baby satisfactorily, while 16 felt some change in breast milk flow, and 7 experienced some mental discomfort (Table 26).

Table 25 - Problems experienced by women immediately following tubectomy

Bleeding	34 (13.9%)
Pain/obstruction during menstruation	12 (4.9%)
Irregular bleeding	4 (1.6%)
Infection in vagina	4 (1.6%)
Headache	58 (23.7%)
Back pain	61 (25.0%)
Chest pain	27 (11.1%)
Shoulder ache	22 (9.0%)
Giddiness & blackout	66 (27.0%)
Weakness	83 (34.0%)
Other	22 (9.0%)
No problems	107 (43.8%)

Source: Survey data, 2002

Table 26 - Effects among those who had tubectomy immediately after delivery

Felt change in breastmilk flow	16
Could attend to baby	74
Felt mental discomfort	7

Source: Survey data, 2002

In terms of long term problems (Table 27), a maximum of 150 to 160 women reported at least one problem, which were mostly weakness, back pain and fatigue. Lower abdominal pain, joint pains, giddiness and blackout were the other significant long-term problems that women reported. There was also worry, depression, palpitation, reduction in enthusiasm which were also mentioned by the women. Further there was also infected white discharge, weight gain, and irregular bleeding which were many in number.

Table 27 - Long term morbidity associated with tubectomy

Type of morbidity	Specific symptoms	No. of women who reported the symptom
Menstrual disorders	Excessive bleeding, painful bleeding, irregular bleeding, amenorrhoea	23 (9.4%) 30 (12.3%) 27 (11.0%) 9
White discharge	Infected white discharge, Painful intercourse	58 (23.7%) 14
Pains	Lower abdominal pain, Back pain Joint pain Haddi tootna	58 (23.7%) 162 (66.3%) 135 (55.3%) 17
	Headache, giddiness and blackout	127 (52.0%) 116 (47.5%)
Weight	Weight gain	55
	Bloated feeling	32
Dryness, itching	Dryness, itching in vagina	8
General Weakness	Weakness	152 (62.2%)
	Fatigue	158 (64.7%)
	Reduction in enthusiasm	48
Menopause	Feeling of menopause at young age	14
	Palpitation	71 (29.0%)
	Hot flushes	53 (21.7%)
Mental/ Emotional	Depression	44
	Worry	94 (38.5%)
	Major change in mental state	20
	Mental tension	18
Effect on sexual desire/ pleasure		15
Effect on work/ productivity		15
Hysterectomy		7
Others		39

Source: Survey data, 2002

It is important to note that women experience these symptoms and relate them to tubal ligation but the health system refuses to acknowledge these. When women were asked about the attitude of public health personnel, only 38 women had any opinion while about 84.4 per cent women (206) said that

they could not say as they used the private health sector facilities. Thus private sector was used very significantly by women for general health care. The attitude of the public health service personnel as experienced by the 38 women who used the public sector is given in Table 28.

Table 28 - Attitude of public health services to women who had already undergone sterilisation

When spoke of problem not attended	33
Considered imaginary and dismissed	26
Considered perpetual and neglected	28
Since lost fertility, no attention given	16

Source: Survey data, 2002

While the above is the attitude to women who have done their sterilisation, it is in contrast to the opinion that women had while they had gone to get their tubectomy done (refer Tables 18, 19, 20). The public health services take good care before the sterilisation is conducted but thereafter do not care much for women when they report their problems.

When observed over time, certain morbidities such as back pain, headache, joint pain, weakness and fatigue was reported in greater proportion by women who had done the operation more than 10 years ago, while infections were reported more by those who did it within a period of 10 years. And even though the proportion of women using the public sector is high compared to the private sector, yet the persistence of the morbidity is high within the public sector (Table 29).

Even though women experience aches and pains quite significantly, doctors we spoke to said that it could be osteoporosis which is common to women approaching menopause. They insist that tubectomy is an extremely safe procedure and women's back pain could have other multiple reasons such as lack of nutrition, early onset of menopause, etc. One of the private practitioners we spoke to admitted that some women do experience depression which was because of hormonal changes due to onset of menopause and not due to tubectomy at all. They were not very concerned that women of younger ages were at menopause. We strongly feel the need to explore the linkages between tubal ligation, early onset of menopause and osteoporosis.

Table 29-Morbidity experienced over a period of time in terms of the place of TL

Type of morbidity	No. of Women who did sterilisation within 10 years		No. of Women who did sterilisation more than 10 years ago	
	Public health service	Private health service	Public health service	Private health service
Menstrual disorders	10 (7.2%)	3 (2.9)	13 (12.5%)	2 (1.9%)
Infected white discharge	36 (25.9%)	5 (3.6%)	17 (16.3%)	-
Lower abdominal pain	38 (27.3%)	5 (3.6%)	14 (13.4%)	2 (1.9%)
Back pain	70 (50.3%)	16 (11.5%)	64 (61.5%)	11 (10.5%)
Joint pain	52 (37.4%)	11 (7.9%)	60 (57.7%)	6 (5.7%)
Headache	51 (36.7%)	12 (8.6%)	57 (54.8%)	7 (6.7%)
Giddiness and blackout	46 (33.0%)	13 (9.3%)	52 (50.0%)	5 (4.8%)
Weakness	55 (39.5%)	12 (8.6%)	62 (59.6%)	8 (7.6%)
Fatigue	62 (44.6%)	16 (11.5%)	69 (66.3%)	7 (6.7%)
Palpitation	31 (22%)	5 (3.6%)	29 (27.8%)	4 (3.8%)
Worry	38 (27.3%)	9 (6.4%)	43 (41.3%)	7 (6.7%)

Source: Survey data, 2002

The method of operation too has contributed to a varied pattern of morbidities over time. Tubectomy continues to give women back pain, joint pains, headache and giddiness over a longer period, while laproscopic TL is proportionately giving the same problems when done within 10 years (Table 30).

Women who approach the health services for these operations already have a compromised health status. In situations like this it becomes the responsibility of the health system to address both the nutritional vulnerability and health care needs before surgery is undertaken.

In terms of anaesthesia used too (Table 31) a significant proportion of morbidity such as back pain, joint pains, headache, giddiness, blackouts, weakness and fatigue is reported by women who underwent spinal anaesthesia more than 10 years ago. Within 10 years it is both general and spinal which has contributed to these and other morbidities.

Table 30-Morbidity experienced over a period of time in terms of type of operation

Type of morbidity	No. of Women who did sterilisation within 10 years		No. of Women who did sterilisation more than 10 years ago	
	Laprotomy tubal ligation	Laproscopic tubal ligation	Laprotomy tubal ligation	Laproscopic tubal ligation
Menstrual disorders	8 (5.7%)	6 (4.3%)	10 (9.6%)	4 (3.8%)
Infected white discharge	25 (17.9%)	16 (11.5%)	13 (12.5%)	3 (2.3%)
Lower abdominal pain	22 (15.8%)	22 (15.8%)	12 (11.5%)	-
Back pain	56 (40.3%)	32 (23.0%)	57 (54.8%)	16 (15.3%)
Joint pain	29 (20.8%)	29 (20.8%)	53 (50.9%)	16(15.3%)
Headache	31 (22.3%)	30 (21.5%)	49 (47.1%)	14 (13.4%)
Giddiness and blackout	37 (26.6%)	22 (15.8%)	47 (45.1%)	10 (9.6%)
Weakness	36 (25.8%)	31 (22.3%)	56 (53.8%)	19 (18.2%)
Fatigue	47 (33.8%)	34 (24.4%)	57 (54.8%)	17 (16.3%)
Palpitation	14 (10.1%)	20 (14.3%)	21 (20.2%)	12 (11.5%)
Worry	26 (18.7%)	23 (16.5%)	35 (33.6%)	15 (14.4%)

Source: Survey data, 2002

Table 31-Morbidity experienced over a period of time in terms of anaesthesia used

Type of morbidity	No. of Women who did sterilisation within 10 years			No. of Women who did sterilisation more than 10 years ago		
	Local	Spinal	General	Local	Spinal	General
Menstrual disorders	-	8 (5.7%)	5 (3.5%)	-	10 (9.6%)	3 (2.8%)
Infected white discharge	5 (3.6%)	22 (15.8%)	14 (10.1%)	-	13 (12.5%)	4 (3.8%)
Lower abdominal pain	4 (2.8%)	22 (15.8%)	17 (12.2%)	-	14 (13.5%)	-
Back pain	6 (4.3%)	53 (38.1%)	30 (21.6%)	1 (0.9%)	54 (52.0%)	15 (14.4%)
Joint pain	7 (5.0%)	29 (20.8%)	27 (19.4%)	-	52 (50.0%)	17 (16.3%)
Headache	5 (3.6%)	29 (20.8%)	29 (20.8%)	-	46 (44.2%)	15 (14.4%)
Giddiness and blackout	7 (5.0%)	37 (26.6%)	19 (13.6%)	1 (0.9%)	41 (39.4%)	12 (11.5%)
Weakness	4 (2.8%)	32 (23.0%)	39 (28.0%)	-	67 (64.4%)	16 (15.3%)
Fatigue	5 (3.6%)	42 (30.2%)	34 (24.4%)	-	57 (54.8%)	17 (16.3%)
Palpitation	4 (2.8%)	23 (16.5%)	25 (17.9%)	-	20 (19.2%)	12 (11.5%)
Worry	-	20 (14.3%)	25 (17.9%)	-	2 9 (1.9%)	2 (1.9%)

Source: Survey data, 2002

Women's morbidities persisted for those who did it more than 10 years ago irrespective of the point at which the sterilisation was conducted (Table 32). However, what is alarming is that those women who had done sterilisation more than 10 years ago immediately after a delivery or MTP had higher proportion of back pain, headache, joint pains, and weakness.

Table 32 - Morbidity experienced over a period of time in terms of point at which sterilisation was done

Type of morbidity	No. of Women who did sterilisation within 10 years			No. of Women who did sterilisation more than 10 years ago		
	Immediately after delivery	Immediately after MTP	Over a period of 2 months to 5 years	Immediately after delivery	Immediately after MTP	Over a period of 2 months to 5 years
Menstrual disorders	5 (3.5%)	2 (1.4%)	3 (2.1%)	4 (3.8%)	2 (1.9%)	4 (3.8%)
Infected white discharge	11 (7.9%)	9 (6.4%)	6 (4.3%)	21 (20.1%)	10 (9.6%)	10 (9.6%)
Lower abdominal pain	13 (9.3%)	10 (7.2%)	5 (3.5%)	20 (19.2%)	12 (11.5%)	8 (7.6%)
Back pain	24 (17.2%)	18 (12.9)	14 (10%)	39 (37.5%)	22 (21.1%)	24 (23%)
Joint pain	16 (11.5%)	12 (8.6%)	14 (10%)	28 (26.9%)	14 (13.4%)	20 (19.2%)
Headache	17 (12.2%)	12 (8.6%)	10 (7.2%)	27 (25.9%)	15 (14.4%)	14 (13.4%)
Giddiness and blackout	7 (5%)	13 (9.3%)	7 (5%)	35 (33.6%)	16 (15.3%)	11 (10.5%)
Weakness	18 (12.9%)	14 (10%)	14 (10%)	27 (25.9%)	24 (23.0%)	17 (16.3%)
Fatigue	23 (16.5%)	18 (12.9%)	11 (7.9%)	16 (15.3%)	15 (14.4%)	9 (8.6%)
Palpitation	8 (5.2%)	4 (2.8%)	7 (5%)	15 (14.4%)	8 (7.6%)	11 (10.5%
Worry	10 (7.2%)	10 (7.2%)	9 (6.4%)	17 (16.3%	13 (12.5%)	13 (12.5%)

Source: Survey data, 2002

Associating hysterectomy as a fall-out of tubectomy on a long term basis

11 women from among the group had done hysterectomy. While 3 of them were unsure of the ages at which the hysterectomy was done, one had done it while she was 27 and another at age 48, while the ages when the others did the surgery ranged from 30 to 39.

7 of these women worked within the home only. 3 women did both paid work outside and work within the home. The paid work of these three women included vegetable selling, construction work and doing odd jobs. One woman did home based work, stitching along with her housework.

Among the problems that precipitated the hysterectomy, most of the women had excessive bleeding ranging from 5 months to a year. One of them had suffered from cancer for nearly 9 years and another had had a tumour. All of them had been suffering from these problems, 1 to 2 years following tubectomy, while one had it after 5 years and another after 9 years.

In all cases the doctors recommended that hysterectomy be done, though one woman said that she was so tired of the excessive bleeding that she requested the doctor to have hysterectomy done. Only two women said they were given hormone injections. Reasons mentioned for the hysterectomy was that it would end the bleeding. Only one woman had a curetting done before the hysterectomy while none of the others received any medicines before the surgery.

Four women took a second opinion from another doctor. All of the women except one said they needed a hysterectomy. 4 women of the 11 had this feeling that their menstruation had stopped at a young age. 5 of them did the surgery at a public hospital, while 6 of them did it at a private hospital and spent between Rs.3000 and 15,000. Only two women had some advice on rest, abstention from sex, and restriction on lifting weights, while the rest of them did not receive any advice or information.

Why does Rani get angry?

A good question to ask me. Yes " I am an angry woman today. I was waiting for this opportunity to talk of the maltreatment that I received during my operation and the complications that I have undergone because of my sterilisation.

"Whom can we tell all this? If we go to the doctors they say this is normal for a woman who has undergone sterilisation. Tell me is it normal to be bleeding almost 12 to 15 days a month for 6 years till I got my uterus out? Is it normal for me to suffer from continuous back pain and headache? My family members are fed up of my complaints. They do not know what to do with me.

I had a tubectomy done 14 years ago in a general hospital. I had conceived 11 times, gave birth to ten children out of which seven are alive, one miscarriage and three died. I was tired of getting pregnant, my health had deteriorated, hence I decided to get sterilised. Little did I realise that I was asking for more trouble.

My experience with the doctors and nurses when I went for sterilisation was not good. They treated us very inhumanly- shouted at us and even beat us. Then my sutures did not heal. The Rs.250 that I got was spent on the doctors fee for dressing the wound.

From the first month after the operation I started bleeding. I could not tell this to anyone and the doctors in the general hospital said it was normal. At last I had to go to a private doctor who checked me properly and said that I had a lump in my uterus and I would need to remove my uterus for the bleeding to stop.

Tell me could this be related to the tubectomy because the bleeding started in the first month itself.

I keep discouraging women from going for tubectomy. I tell them my experiences. Can't the government do something about this? They can tell the doctors how they should behave with us when we come with complaints and treat us. More thought needs to be given to this removal of the uterus after tubectomy. Now you know Ki Rani Ko Gussa Kyon Ata Hai!

Support and social implications

Help from family during operation

One family member or a combination of relatives and neighbours accompanied women when they went for the sterilisation operation (Table 33). For 76 women their husband alone accompanied them, while for 37 women their mothers came along with them. For nearly 100 women, a combination of relatives such as in-laws, mother, other relatives and neighbours went along with them. Only 20 women were unaccompanied. What is interesting is that apart from the husband almost all the women were accompanied by other women. Thus women were great support for each other in times of need.

Table 33 - Person who accompanied women for tubectomy

Husband	76
Mother	37
Sister	5
Other	101
Neighbour	5
Combined help	60
Nobody	20

Source: Survey data, 2002

75 per cent of women (183) received special help from family members to take care of them, the house and the children, while 28 women received no help of any sort. 33 women did not require help as they already lived in situations where there were people to take care (Table 34).

Table 34 - Help specifically received at home

All help given by family	183 (75.0%)
Did not require special help	33 (13.5%)
Nobody for help	28 (11.5%)

Source: Survey data, 2002

74 women (30.3%) did not have to stay in the hospital, but 170 (69.6 %) had some period of hospitalisation (Table 35).

Table 35 - Days spent in hospital by the women for tubectomy

No stay in hospital	74 (30.3%)
1 to 3 days	61 (25.0%)
4 to 6 days	26 (10.7%)
7 to 9 days	65 (26.6%)
10 to 20 days	15 (6.1%)
1 to 3 months	3 (1.2%)

Source: Survey data, 2002

Women also incurred considerable expenses for the operation irrespective of it being public or private health services (Table 36). This was apart from the expenditure on transport, food, childcare and on people who accompanied them (Table 37). Hence this demolishes the myth that poor women undergo sterilisation because they get incentives from the government. The costs of drugs and other expenses is much greater than the paltry sum they get as incentives.

Table 36 - Expenses incurred for the operation

Amount of money spent-Rs.	Public health service	Private service
50-200	34	8
201-500	28	7
501-1000	8	2
1001-3000	3	-
15,000	1	-
40,000	1	-
Did not know	12	3
Did not spend	124	13
Total	**211**	**33**

Source: Survey data, 2002

Table 37 - Expenses outside of operation (transport, food, childcare, people)

< Rs 250	59
Rs 250-500	23
Rs 500-1000	4
Rs 1000-2000	2
Rs 2000-3000	3
Rs 3000-5000	1
Did not spend	151

Source: Survey data, 2002

Who decides?

48.3 per cent of the women (118) made the decision along with their husbands to do tubectomy. 37.7 per cent women (92) decided on their own, while for 23 women, their husbands made a choice (Table 38). There is seeming cooperation from the husbands, but women also said that poverty played an important role when making this decision.

Table 38 - Persons who chose tubectomy

Self	92 (37.7%)
Husband	23 (9.4%)
Self and husband	118 (48.3%)
Parents in law	5 (2.0%)
Others	2 (0.8%)

Source: Survey data, 2002

Male responsibility

Men have mostly taken a back seat when it comes to taking up reproductive responsibilities supporting it with myths and excuses. In a situation where they refuse to do so women choose to undergo sterilisation thereby subjecting themselves to surgical and post-operative problems. In order to understand this, the attitude to male vasectomy is a revelation (Table 39).

There are widely prevalent notions that the partner will become weak and lose his masculinity. 30 per cent of the women said that their partners refused to do vasectomy. Among other reasons, 23.3 per cent said that it is better for women to do the operation as they stay at home while the men go out to work. The women felt that it was their contribution to shouldering the economic responsibility of the family. In a situation where women's productive work is not acknowledged they feel that they are making a social contribution by taking over this responsibility.

Table 39 - Reasons for not choosing male vasectomy

No knowledge	39 (16.0%)
Partner did not agree	73 (30.0%)
Fear of effect on partner's virility	48 (19.6%)
Fear of partner becoming weak	137 (56.1%)
Other	57 (23.3%)
NA	10 (4.1%)

Source: Survey data, 2002

Power to negotiate

Regarding the increase in demand for sex from partner, about 11.5 per cent women (28) said that demand had increased, while 25.4 per cent women (62) did not find increased demand. 152 women (62.3%) found it not applicable (Table 40). Many of them stated that it was either the same or they did not have relations with their men.

Table 40 - whether demand for sex had increased

Yes	28 (11.5%)
No	62 (25.4%)
Not Applicable	152 (62.3%)

Source: Survey data, 2002

Even after tubal ligation most women felt they did not have the space to negotiate sex with their partners. Though some said that their sexual desires had diminished considerably, all of them felt sexually liberated that they could have sex without the fear of conceiving. It is important to further explore women's perceptions of their sexuality - of pleasure, desire and their relationship to their bodies and others.

Almost 90% of the women did not have any information on HIV/AIDS, and hence were not aware of its severity and the need to have safe sex. Even where other STIs were concerned they expressed their powerlessness to decide on sexual matters.

We feel much concerned about the women under the age of 35 years who have been experiencing the signs of early onset of menopause. Of the 127 women of this age group 26.0 per cent experienced palpitations and 22 per cent had hot flashes and sweating spells.

Discussion

1. The most significant finding of the study is **the association of morbidities with sterilisation**. This becomes a counterpoint to what medical literature (as cited in Turney; 1991) has to say. The medical establishment and literature says that tubal ligation is an extremely safe procedure with no side-effects. In our study women have reported multiple morbidities following sterilisation such as menstrual disorders, infected white discharge, back pain, joint pain, head ache, giddiness, blackout, weakness, fatigue and palpitation, consistently extending to a period more than 10 years. In fact the study done by Sabla Sangh in the late eighties also had women associating the same proportion of morbidities with tubal ligation. This shows that over the years nothing has changed for women who have undergone sterilisations.

2. The **timing** of the operation was significant to the understanding of the morbidities that women experienced. Even though the proportion among those who did it immediately following delivery had come down over a period of ten years, still the numbers continue to be alarmingly high. We need to question this attitude especially when tubal ligation immediately following delivery is medically inadvisable. Encouraging institutional deliveries is one way of making women available for sterilisation.

   Besides tubal ligation following MTP has risen considerably over the last 10 years (28%). This means that increasing number of women are using MTP as a contraceptive method. This could also mean that within the public health services tubal ligation is used as a pre-condition for MTP, highlighting the fact that coercive practices continue to prevail within the family planning services. Nevertheless since women continue to approach the health services for MTPs it becomes absolutely necessary that the government provide safe abortion facilities at all times and all places without any conditions.

   Men refuse to co-operate in adopting a contraceptive driving women to repeated MTPs. The area for negotiation is fast diminishing between partners and women's vulnerability tends to get exploited by men and the health services. The vulnerabilities in the conditions in which women choose to do tubal ligation hardly finds any space in counselling, advice or follow-up. Doctors it seems have left it to women's preparedness and decisions.

3. In terms of the **methods** used for sterilisation by the health services, laprotomy tubal ligation formed the predominant method for those who did it more than 10 years ago (70%), while laproscopic tubal ligation formed 25 per cent. However within the last 10 years, the use of the laproscopic method has increased tremendously. The rationale of the health system is that this method is quicker and more efficient. But women's perceptions indicate that they are not in favour of laproscopic tubal ligation for the following reasons: awareness of the possibility of failure, being scared of electric shock during the laproscopy, having fearful recollections of camp situations, trainee doctors performing on them, operations conducted at night and fear of spinal anaesthesia used earlier. Our study also points to the fact that there are greater risks associated with laproscopic tubal ligation such as rupture of blood vessels etc.

   Another important factor observed was that tubal ligation was being done during caesarean section. Doctors find it convenient to ligate the tubes during a caesarean, but our study reports that majority of sterilisations done in such cases ended as failures. Further such situations have greater abuse potential especially with respect to consent.

4. In each of the interventions, the type of **anaesthesia** used was an important factor in the morbidities that women reported. Earlier (more than 10 years ago) spinal anaesthesia was more in practice along with laprotomy tubal ligation. In the last 10 years the use of general anaesthesia has increased as laproscopic tubal ligation demands it. The use of spinal anaesthesia is reflected in persistent morbidities such as back pain, headache, joint pain.

5. The intensity of the morbidity and its **chronicity** persists in terms of the method and the type of anaesthesia used. For instance a higher proportion of women who reported back ache, headache, giddiness and blackout had spinal anaesthesia used on them. This underlines the fact that we have been reiterating that the health services need to provide women who undergo sterilisation with sufficient post-operative care. Post-operative care and general health care for women following sterilisation is an area that is totally neglected by the public health services. On the contrary the health system has trivialised and dismissed women's reporting of morbidities. They have instead projected these as normal.

6. The perpetuation of the myth of **normality** of the post-sterilisation morbidity has continued, and the health services have contributed in

transferring these notions of normalcy on to women who have internalised them. Not only is the process of normalisation evident with respect to experience of morbidities but the easy acceptance of the sterilisation itself. In fact doctors even spoke of women's preparedness to do sterilisation thus putting a stamp on the coercive strategies of the country's family planning programme. Rather than engaging the men to adopt contraception the health services compel women to undergo sterilisation. On part of the women, some say slight back pain is normal and acceptable. Women say problems are there but what can be done, it all has to be accepted. Women see their health problems relative to others, satisfied that their own problems are not as serious as others.

7. While the government continues to dominate in providing family planning services, there is a slow shift towards the private sector. The reasons for this trend needs in-depth exploration and we need to know why or who are the people who are opting for the private sector.

8. Further, women have assumed the **responsibility** of permanently limiting their families onto themselves and completely absolved men of any role in doing so. There is also the overwhelming dominance of the myth surrounding male vasectomy.

Recommendations

We make the following recommendations based on the continued demand by women for sterilisation given their conditions of vulnerabilities, risks and 'choice'.

1. We strongly recommend that the government provide women continued health care following sterilisations. Our insights from the morbidities that women report compel us to make this recommendation that women who have undergone sterilisation should receive health care free of cost and their problems not be dismissed as imaginary or inconsequential. The health services should in fact provide these women with continued post-operative care with special OPDs. Besides the health system should also take into account women's health and nutritional vulnerability prior to operation.

2. Since women prefer sterilisation to other contraceptives it should be the government's responsibility to ensure that sterilisation is carried out in the safest way possible. The study reveals that the manner of operation and the type of anaesthesia used is related to the morbidities. Hence there should be a review of the use of these methods. The use of spinal anaesthesia should be re-examined.

3. Laproscopic sterilisation should be discontinued. Women's perceptions of the problems in relation to laproscopy should be acknowledged and the choice of sterilisation should be left to women rather than impose any method.

4. Sterilisation should not be done immediately following delivery or after abortion. The high proportion of morbidity in the post-partum period and the post-MTP phase makes this recommendation imperative. This linkage only strengthens the fact that the government continues with its coercive manner of offering family planning services, and this should therefore be discontinued.

5. With the age at tubal ligation decreasing, more research needs to be done on the consequences of this phenomena.

6. One of the immediate post-surgical problems is the delay in healing of wounds, therefore the public health services should provide conditions of absolute sterile techniques.

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Appendix-1

Interview Schedule

Name:

Age: Age at Marriage: Age at Tubectomy:

Native Place: Caste: Religion:

Occupation: Seasonal Migration

Activities: Paid and unpaid: Hours of work:

Income

Number of persons in family: No. of children: Male Female

I. Contraceptive History:

1) Have you used/have knowledge of any of the following spacing methods?

	Knowledge	Use	For how long
Natural family planning			
Abstinence			
Coitus Interruptus			
Diaphragm			
Condom			
Oral Pills			
I.U.D.			
Injectibles			
Spermicides - Today			
Implants			
Any other			

2) What did you like about it?

It was safe
Gave enough privacy
No menstrual irregularity
No aches and pains
Enjoyed intercourse without any tension
Any other reason

3) Why did you discontinue spacing methods ?

Wanted more children
Had menstrual problems
Unsafe and unreliable
Discomfort in intercourse
Partner objected
Any other

II How Tubectomy becomes a choice

1) Why did you choose Tubectomy?

Illhealth
Did not want any more children
Tired of using spacing methods
Wanted tension free sexual relationship
Fear of conceiving
Did not want to undergo more abortions
Stigma/ Fear of being labeled
Any other

2) Why not Vasectomy?

Did not know about Vasectomy
Partner not cooperative
It will affect his energy
Make him impotent
He will demand for more sex
Any other

3) Who made the decision of Tubectomy ?

Self
Husband
In-laws
Parents
Friend/neighbour
Any other

4) Were there any pressures to choose Tubectomy? If yes, then

Incentives
Disincentives
Poverty
Pestering by health functionaries
Employer
Propaganda
Any other

III Processes of the Operation and its Immediate Effects

1) When did you get tubectomy done?

2) Where did you get tubectomy done?

Camp — How many were there?
Maternity Centre/public hospital
Private

3) How far was the venue?
In the area
Away from the area

4) Where was it held?
School
Maternity centre
Community hall
Any other

5) Who accompanied you ? Not accompanied.

6) What support system was there?
To look after children
To carry out your domestic work
To take care of you

7) What type of operation did you undergo?
Tubectomy
Laproscopic tubal ligation (TL)
Quinicrine sterilisation
Any other

8) Was it in the OPD or were you admitted? How many days were you there?

9) Was the operation immediately

after Delivery
Abortion
After a gap
Contraceptive failure

10) Who recruited you ?
ANM/MPW/CHW
Teacher
Any other

11) How were you motivated ?

Given Incentives	in cash	in kind
Fear of disincentives		
Threatened		
Given information		

12) Did you have any fears before undergoing operation such as
- Tension about household chores due to immobility
- Permanent loss of fertility
- Irreversibility
- Of surgery itself
- Of complications and death
- Any other

13) Was any information given to you at the time of the operation? Yes No

14) Who gave it to you?
- Social worker
- Doctor
- ANM

15) What information was given to you about the operation?

On Procedure -
- Description of the procedure
- Type of anaesthesia
- risk and accidents
- position of surgery

Contraindications: Skin condition at the site of the operation.
- Anaemia
- Blood pressure
- Diabetes
- Pelvic Infections
- Allergies - auto immune disorders

Side effects
- Bleeding
- Pain
- Failed abdominal insufflation
- Burns
- Direct trauma to other pelvic organs and blood vessels
- Shock
- Numbness of the lower limbs
- Any other

16) Who gave consent for the operation?

Self
Husband
Parents
Inlaws

17) How many women doctors/nurses were there at the time of operation?

18) What was the attitude of the staff?

Humiliating
Apathy
Uncaring
Inhuman

19) Were you and your partner given any counselling? Yes No

20) Were any tests carried out? If yes, what tests were carried out ?

Hb/Blood count
Urine/Blood for sugar
Blood Pressure
Allergy testing

21) What immediate preparations were done ?

Medication
Local hygiene

22) How was the atmosphere in the O.T.

Well Lit
Proper Operation table
Temporary O.T.
Instruments sterilised.

23) What Anasthesia was given ?

Local
Spinal
General

24) How was the environment?

Clean
Crowded
Humid
Tense

25) After surgery were you given
medication,
advice on follow up
rest
intercourse
after effects of surgery - Bleeding
Aches and pains
Vaginal infections
Any Other

25) Did you have any immediate problems like -
Bleeding
Back pain
Cramps/menstrual pain
Unexplained pain and change in bleeding
Weakness
Vaginal infections
Head ache
Giddiness/ Blackouts
Chest pain
Shoulder pain
Any Other

26) If tubectomised immediately after delivery
Effects on breast milk
Proneness to infections
Neglect of the newborn
Mental illhealth

27) Did the wound heal properly? Yes No

28) How much was spent on the day of operation itself?
Transport
Food
Medication
Care of children
Person accompanying

29) Did you pay for the operation? Yes No How much?

30) Did you pay for medication? Yes No How much?

31) What was the follow up?
Did ANM visit you ?
Were you called to the Maternity Centre?

IV Safety & Effectiveness/ Long Term Problems

1) Do you think the operation was a success?
   Yes
   No

2) What makes you think the operation has been a success? If yes
   Because you have not conceived
   You have not had any health problems
   It has not affected your energy levels
   Free from anxieties and worries
   It is permanently liberating
   You have been sexually active

   If No:

   Because of recurrent health problems
   It has affected energy levels
   Trauma of unexpected pregnancy / abortion.
   Misunderstanding among partners
   Convincing doctors about failure of procedure
   Need for second tubectomy

3) Have you had any persistent or recurring long-term problems?

	Occurred	For how long
Excessive bleeding		
Painful bleeding		
Irregular bleeding		
Amenorrhoea		
White discharge - smelling, coloured		
Lower abdominal pain		
Back pain		
Head ache		
Giddiness/ Blackouts		
Weight gain		
Feeling of bloatedness		
Dryness in the vagina/itching…		
Growth of excessive hair on the body		
Painful intercourse		
Any other		

General weakness
Fatigue,
Loss of energy, vigor
Joint pains
Fractures

Early menopausal symptoms
Palpitations
Hot flushes
Menstrual changes - irregular/heavy bleeding etc.
Fear of STDs

Depression
Anxiety
Mood swings
Tension

Effect on Libido
Desire, pleasure

Work/Productivity
Survival of children
Gender biases - Feeling more discriminated
Desertion

Hysterectomy
Tumours/ Lumps
Breast Cancer
Any Other

Death

V. Social dimensions of life after Tubectomy :-

1) Are there any changes in your relationships ?
Feel more liberated
Able to enjoy sex
Unable to deny sex
Suspicious

Space to negotiate in household decisions
Feeling of useless or unproductive

2) Do you feel it is not necessary to worry about your health anymore? Yes No

3) Are you regretful for getting operated due to loss of child/son?

4) Attitude of the medical establishment towards those who are tubectomised
   - Not taken seriously when you report health problems
   - Connect my problems to imagination
   - Dismiss my problems as being normal
   - Neglect me because now I no longer reproduce

5) Increase in social problems as age at tubectomy keeps decreasing
   - Family members become less sympathetic
   - Feeling aged
   - Not able to cope with early menopausal symptoms
   - Loss of one's status in the community
   - Feeling insecure

6) Have your been deserted because of tubectomy? Yes No

7) Have you ever thought about the process of Recanalisation? Yes No

8) If yes then what action you took
   - Consulted the Centre where tubectomy was performed
   - Consulted any other private doctors
   - Went to unqualified practitioners
   - Took medication
   - Underwent surgery

9) How long did it take?

10) What were the expenses incurred?

VI Linking Tubectomy to Hysterectomy

1) Have you undergone Hysterectomy and at what age?

2) What were your complaints and how long did you have them?

3) After how many months/ years following tubectomy did you have the complaints?

4) Who advised Hysterectomy and when?

5) Were you given hormonal therapy?

6) What reasons were given in support of hysterectomy?

7) Did you discuss your complaints with anyone?

8) Was any other treatment given before you were hysterectomised?

9) Did you take a second opinion?

10) Do you think hysterectomy was really necessary?

11) Was it partial / total / radical?

12) Are you experiencing any early menopausal symptoms since?

13) How much did you spend for Hysterectomy?

14) Where did you get operated - Government hospital
Private nursing home

15) What information was given to you before and after Hysterectomy?

Protection from HIV/AIDS, STDs:

1) Has the demand for sex increased?

2) How do you protect yourself from STD/HIV?

3) Have you felt it is important for partner to wear condom after tubectomy?

4) Do you practise any other ways of making love to avoid infections?